NHS
Yorkshire and the Humber
Clinical Networks

# IAPT PBR Workshop 20.07.17

# Q&A Summary

**Questions to Sue Nowak and Robert Melnitschuk, National Pricing Team:**

1. **What is going to happen to services if we do not go live with the new payment system on 1st April 2018? How will this be performance managed?**

The responsibilities to monitor compliance with the national tariff rules lie with NHS Improvement. NHS England is currently seeking clarity from NHS Improvement regarding how compliance will be performance managed. As soon as this is known the information will be shared.

NHS England would encourage Providers and CCGs to be pragmatic around implementing the new pricing system. Progress towards implementation could be for services to link payments to quality and outcome measures to improve and reflect local system priorities. The East Midlands region has undertaken some work in this area, which could be drawn upon by other areas. NHS England is looking to capture and share work by Providers and CCGs to support wider progress.

2. **Regarding the interim currency tool how do we access this?**

Please email robert.melnitschuk@nhs.net regarding the opportunity to become a trailblazer site for the currency tool.

3. **You have advised that the payments will be based 95% on activity and 5% on outcomes. Why is the focus on activity over outcomes?**

NHS Improvement has set the split for this payment approach. This also reflects the reality of current payment arrangements where few Providers and CCGs have agreed to link payment to quality and outcome measures. NHS England would encourage localities to consider what would be a pragmatic split for local services reflecting on current priorities, and payment arrangements.

Some areas are already looking to link more than 5% of contract values to quality and outcome measures for example, in Islington the local payment has been agreed to be based on 23% outcomes and 77% activity. Likewise in Oxford the split has been agreed as 40% outcomes and 60% activity. Providers and Commissioners are encouraged to discuss locally what approach would best work to mitigate against ongoing risk and promote continuous improvement.

4. **Is the pricing model being developed based on PLICs or other models?**

NHS Improvement is considering a number of models to develop their costing information, which will be helpful to localities when setting the tariff. For mental health services it is essential that costing is linked to outcomes. There is also some non-mandatory pricing in development.

5. **Is an integrated governance group being utilised to develop the costing model?**

Integrated governance groups are the best practice method for ensuring representation and engagement from all relevant stakeholders and provide an opportunity to involve service users, which is essential to identify the quality and outcomes measures that matter most to them when developing an outcomes-based payment approaches.

6. **Regarding the split between 95% activity and 5% outcomes is this your recommendation for Providers and Commissioners to take forward?**

We recommend this split as a starting point when developing and implementing an outcomes-based payment approach. Localities should consider what would be a pragmatic split to suit local circumstances.

If local areas want to be more ambitious and to link a higher % of contract value to the 10 set outcome measures this would be consistent with the rules. NHS England is already aware of some contracts which have agreed much more than 5%.

Further, some areas have reviewed current provider performance against the 10 quality and outcome measures. Organisations in the East Midlands decided not to link 2-3 of the measures to payment as performance was very good but they will continue to monitor performance.

7. **Funding is often raised as an issue following intervention from the Intensive Support Team. If there is no national tariff is local determination the way to proceed?**

It is not our ambition to take funding away from services. We feel this payment approach will bring transparency to ensure that investment, or lack of it, is highlighted. NHS England and NHS Improvement are also looking into the possibility of developing non-mandatory prices.

8. **What is payment going to look like for IAPT-LTC?**

This is currently being explored with the National Policy Team.

**Questions to Kit Hadley-Day, NHS Digital:**

1. **How do services sign up to become one of the trailblazer sites?**

We have 100 user licenses to test the tool. To request to become a trailblazer site please email robert.melnitschuk@nhs.net.

2. **If you put forward to become a trailblazer site what support will be on offer?**

There will be a generic email address to be used for queries and the Digital Casemix team will also be providing support.

3. **Please could you explain how services will be able to understand the tool, as it will not contain any local data?**

The tool will initially contain synthetic data that will allow services to see the tool in action. The synthetic data will also allow services to understand the reference data that the tool will require going forwards. NHS England and NHS Digital will be trying to connect with Clinical Networks to attend meetings to demonstrate the tool.

4. **How does the tool calculate payment when a patient may change from Step 2 to Step 3?**

The tool uses clusters rather than the stepped model of care, and we are aware of that service users may be re-clustered during treatment. NHS Digital and NHS England will explore if this can be reflected in the tool. Separately, we will explore options for the stepped model. We hope to work with some of the trailblazers to see if and how this can be done.

5. **Can you explain how the payment is linked to clustering?**

Previous work with the national IAPT PBR pilot identified a correlation between cluster number, intensity of treatment and cost. The tool is structured so that the localities will need to develop prices for each cluster and input them into the tool..

6. **If a cluster changes what then happens with the payment?**

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7. **How will the payment tool calculate payments for patients who are seen across different providers?**

The tool does not have that functionality. A change in provider will start a second pathway.

8. **Can you aggregate the 10 outcome measures for benchmarking?**

The tool has this functionality; it looks at all 10 outcome measures and produces a final number. Analytically NHS Digital do not look at this but users of the tool will be able to analyse the data in this way by building their own metrics based on the dataset in Exeter**.**

9. **The fact that the tool does not include any method for capturing step changes is a huge issue. What will be done going forwards to rectify this?**

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10. **The tool is based on completed treatments and not on assessments why?**

The tool has been based on the clustering model that was included in the original IAPT policy from 2008; the focus of that policy was on clustering and not on treatment. We are considering ways in which to incorporate stepped care into the tool.

**Questions to Andy Sainty, AQP Provider:**

1. **What is classed as completed treatment?**

Varies between service lines and tariffs, Basically, this payment is triggered:

a. At step 2 if a patient is discharged as recovered (moved from caseness to non caseness) between 3 and 6 sessions - but not if fewer than 3 sessions where only the entered treatment tariff would be paid.
b. Or, at session 6 of step 2 for a patient who has not recovered and who is not suitable or eligible for further treatment at Step 3 i.e. discharged from IAPT following maximum dose of therapy.
c. At Step 3 – completed treatment payment is triggered if a patient is discharged and has received a minimum of nine sessions without achieving recovery. If they are discharged before reaching session 9, then only the entering treatment tariff is payable, and if they commenced treatment at step 2 and were stepped up during treatment, it is the step 2 entering treatment payment that is received.
d. At step 3, if a patient recovers (moves from caseness to non caseness) we receive the recovery payment and potentially patients can recover in less than 9 sessions so we would receive payment – no recovery payment can be made if fewer than 3 sessions though (although this is rare anyhow). If a patient recovers within a few sessions, our team continue to offer several more sessions to ensure this is sustainable recovery and do not discharge as soon as scores indicate recovery.
e. We also offer post discharge follow up across all steps and modalities as long as the patient has completed treatment (as opposed to dropped out) but receive no payment for this additional session.

2. **Your service seems quite focussed on data quality – how did you work with your staff to encourage a data quality culture?**

We have undertaken a significant amount of training. We conduct quizzes to test knowledge and highlight where further training may be required. We advise of staff of the rationale for collecting data and we have a system that can demonstrate to patients in graph form changes in their scores, which is helpful in facilitating recovery. We embed data and performance reporting into team culture and induction.

3. **How do you move your HIT staff around your locality?**

With difficulty! The first thing we consider is staff workload in the area in which they work, we then condense this and start moving the staff member bit by bit to a new locality essentially condensing their workload in one area and growing it in another area. For part time staff we tend to start restricting their caseload and Step 2 staff undertakes SilverCloud or CCBT work in the interim before a final move to a new location. Our staff are also very flexible, which is helpful. By closely monitoring capacity, demand and productivity we can limit moves by ensuring we have the right mix of therapies in any given area.

4. **Do you have any top tips on the essentials of implementing PBR?**

Knowing your data! If you know your data inside out you will know exactly what you can and what you cannot deliver. Conducting a data deep dive is essential. It is also very important to understand your locality and ensure treatments are delivered to fit around local variation. For example, in our locality part of our patient cohort includes trawler men and so our treatment times are based around tide times and fishing timetables. Lastly, ensure your service has a strong focus on staff wellbeing. Don't expect to reach break-even in the first 9 months – you will probably run at a loss for the first 6 months depending on what model you use as the hardest part is culture change and having confidence in decision making based on data quality – as this improves so does the accuracy of decisions re capacity and demand.

5. **For your full time staff working 37.5 hours per week – how much of this time is clinical?**

For HIT there are 22 hours of clinical contact time per week plus 3 hours clinical supervision per month and 3 hours caseload/performance management and clinical skills groups once a month. For PWPs they are expected to conduct 35 clinical contacts per week, 3 hours clinical skills per month, 3 hours caseload management, performance supervision and groups – at least one group per week each.

6. **How do you monitor staff morale?**

It is focussed on in clinical skills sessions and we also have a silly questions box and an anonymous whiteboard for people to pin up issues they are experiencing. If we have any urgent issues, such as contractual changes, that require intensive discussion we have the capacity to shut down the service and bring all staff together to talk things through although this has been affected by a recent move to a new therapy centre as we don't have enough chairs until they are delivered!

7. **Regarding the direct access into groups how do you manage the risk?**

We have to offer direct access to patients because we are contracted to offer this and we encourage patients to call in to make a booking so we can assess them over the phone. Additionally, we have well trained staff managing the groups with usually 2 fully trained staff and a trainee in attendance to assess patients and manage risk as appropriate.

We market our groups and take online referrals for groups which allow us to take some details and all self-referrals have to complete a mini risk assessment with different splash screens displaying if risk is indicated – e.g. high risk would advise the referral is not suitable and prevent it being completed but signpost to crisis services etc. Medium risk would prevent acceptance but signpost to Samaritans, GP, Secondary Care gateway etc. We would accept ideation with low intent but not a referral with ideation, high intent and motivation.

**Additional questions collected after the event:**

**Question to Sue Nowak and Robert Melnitschuk:**

1. **What is the time commitment and what hoops need to be jumped through in order to become a trailblazer?**

Trailblazers will have access to the current version of the tool which will be loaded with 'dummy' data. This will allow sites to explore the functionality of the tool in a safe environment and to provide NHS Digital and NHS England with feedback to inform further development of the tool. Sites will be given log in details to access the tool at a time convenient to them but we would encourage participating organisations to provide robust feedback.

2. **How do you apply CQUIN to the proposed model?**

CQUIN guidance applies to commissioners and providers using the NHS Standard Contract in 2017–2019. It is expected that CQUIN should be applied outside of this model – the proposed payment approach is intended to be applied to funding for IAPT services, which will contribute to a provider's contract AAV; CQUIN is to paid as a premium over and above a provider's contract AAV.

Full guidance on the application of CQUIN schemes is available:
https://www.england.nhs.uk/wp-content/uploads/2016/11/cquin-2017-19-guidance.pdf

3. **How do you resolve the differences between cluster levels and stepped care model interventions?**

Developing an outcomes-based payment approach for adult IAPT services published on 27 January 2017 made clear that this was intended for cluster-based episodes of treatment. This payment approach is consistent with local pricing principles and rules set out in the 2017/19 national tariff. The approach would take into account service user complexity and related intensity of treatment.

Some commissioners and providers may wish to develop and implement alternative payment approaches including using the stepped care model as the basis for payment. Alternative payment approaches would need to comply with the local pricing principles set out in the 2017/19 National Tariff:

- Rule 1: Providers and commissioners must apply the local principles in Section 6.1 when agreeing prices for services without a national price
- Rule 2: Commissioners and providers should have regard to the efficiency and cost uplift factors for 2017/18 and 2018/19 (as set out in sections 4.7 and 4.8 of this document) when setting local prices for services without a national price for 2017/18 and 2018/19, respectively
- Rule3: Commissioners must use the national currency for the service if there is one, and can only depart from such a national currency by following the requirements of rule 4.

Further, alternative outcomes-based payment approaches would need to comply with the specific local pricing rule 8 and guidance which relates to payment for IAPT services:

- A requirement to link an element of payment to the 10 national quality and outcome measures
- Reflect service user complexity and intensity of treatment in payment approach/prices
- Continue to flow information to the national IAPT data set (including cluster data).

4. **Some of our IAPT services are not pure IAPT services. Do we apply the payment model only to the IAPT elements?**

Developing an outcomes-based payment approach for adult IAPT services published on 27 January 2017 made clear that this was intended for standalone services. Reflecting broader changes to payment and the focus of the Five Year Forward for Mental Health on improving quality and outcomes we encourage commissioners and providers to explore the development and implementation of payment approaches that will incentivise these improvements.

5. **Is there some national data available regarding the 10 quality and outcome measures?**

NHS Digital processes and publishes national IAPT data which covers the quality and outcomes measures. Further information can be found on NHS Digital's website http://content.digital.nhs.uk/iapt.